



LUND UNIVERSITY

Asthma and allergy: the significance of chronic conditions for individual health behaviour.

Bolin, Kristian; Lindgren, Björn

Published in:
Allergy

DOI:
[10.1034/j.1398-9995.2002.10xxx.x](https://doi.org/10.1034/j.1398-9995.2002.10xxx.x)

2002

[Link to publication](#)

Citation for published version (APA):

Bolin, K., & Lindgren, B. (2002). Asthma and allergy: the significance of chronic conditions for individual health behaviour. *Allergy*, 57(2), 115-122. <https://doi.org/10.1034/j.1398-9995.2002.10xxx.x>

Total number of authors:
2

General rights

Unless other specific re-use rights are stated the following general rights apply:
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Read more about Creative commons licenses: <https://creativecommons.org/licenses/>

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

LUND UNIVERSITY

PO Box 117
221 00 Lund
+46 46-222 00 00

Original article

Asthma and allergy: the significance of chronic conditions for individual health behaviour

Background: In health economics, health is regarded as part of an individual's human capital. As such it depreciates over time, and investments in health are made in order to keep the stock of health capital at the desired level. Using this framework for analysis of health-related behaviour and Swedish panel data, we examined whether the presence of asthma or allergy affects perceived health and investments in health.

Methods: A set of panel data for approximately 3800 individuals interviewed repeatedly in 1980/81, 1988/89, and 1996/97 was created from the Swedish biannual survey of living conditions. Self-assessed health was chosen as the indicator of health capital and the reported number of sick days as the indicator of health investment. The presence of asthma or allergy, age, wage rate, wealth, marital status, number of children, exercise and smoking habits, gender, and geographic location of household were all chosen as explanatory variables. An ordered probit model was estimated for the health equation and a Poisson model for the investment equation.

Results: We found that both asthmatics and those who suffer from allergy invested more in their health than the general population. We also found that asthmatics reported significantly lower self-assessed health than the general population, while those who suffered from allergy did not differ significantly from the general population regarding their self-assessed health.

Conclusion: The human capital approach was found suitable for studying the impact of asthma and allergy on individual health behaviour. Health policy measures, which reduce the individual's costs of investing in his or her health, would improve health levels. Because asthmatics were found less healthy than those suffering from allergy, the potential gains would be larger for patients with asthma than for patients with allergy. The issue of whether this would be a cost-effective policy or not would require a different design and, hence, could not be solved within the present study.

K. Bolin, B. Lindgren

Lund University, Department of Economics,
Department of Community Medicine, and LUCHE (Lund
University Center for Health Economics), Lund
University, SE-220 07 Lund, Sweden

Key words: allergy; asthma; economics; Grossman
model; health behaviour; self-assessed health.

Dr K. Bolin
Department of Economics
Lund University
PO Box 7082
SE-220 07 Lund
Sweden

Accepted for publication 4 October 2001

Asthma and allergy inflict suffering in a variety of ways for those individuals who are stricken with these diseases. An individual who suffers from asthma or allergy may be forced to change his or her lifestyle in order to avoid, or reduce, allergic reactions, and to spend a lot of time in the health-care system. Other activities, such as working, studying or enjoying one's leisure time, will have to be diminished. Furthermore, those suffering from asthma or allergy may experience reductions in income as a consequence of absence from work and less paid employment. Additionally, not only the individual who suffers from asthma or allergy is affected but also that individual's family, for example, because the environment in the home may have to be adapted to the preconditions of the affected individual. Also, for society at large, there are significant public health consequences from asthma and allergy, because

they reduce the well-being of a substantial and increasing share of the population in most countries, even though the prevalence rates may differ (1–7).

Thus, asthma and allergy not only cause significant personal sufferings but they also have a substantial economic impact on society at large. In Sweden, for instance, asthma and allergy accounted for approximately 2% of the total costs of illness both in 1980 and in 1991 (8–10). The share of asthma was 52%, while allergy (here consisting of the three diagnoses rhinitis allergica, eczema atopicum prurigo Besnier, and eczema allergicum) together accounted for 48%. Indirect costs (loss of productivity) accounted for the major part (63%), while outpatient care (GP visits included), pharmaceuticals, and inpatient care accounted for 19, 11, and 7%, respectively, during 1991. Productivity losses and inpatient costs decreased whereas outpatient and, in

particular, pharmaceutical costs increased between 1980 and 1991. Similar findings on the economic impact of asthma and allergy have been reported from other countries, for instance, the United States (11–17).

The total cost of asthma and allergy is the result of a number of interdependent factors: for example, the prevalence of disease, the medical technology used, and the incentives to patients and doctors created by the way health care and insurance systems are organized. Therefore, the estimated cost is dependent on time and place. Differences in the regulation of health care or health insurance may explain differences in estimated costs among countries, moreover the opportunity cost of illness may change over time in a specific country, because of improvements in medical technology, changes in the prevalence of disease, changes in overall productivity, or changes in individual behaviour (18).

Individual behaviour is a crucial determinant of the cost of illness, and understanding individual health-related behaviour is essential, for instance, for policy-making. A central theoretical model for analyzing health behaviour within health economics is the ‘demand-for-health’ model introduced by Grossman (19, 20). Further developments of the model include (21–26); for a survey and review, see (27). According to this model, the individual both demands and produces his or her own health. Naturally, the notion of ‘producer of health’ does not mean that the individual determines his or her state of health – heredity, environment, and chance are three factors which may interfere – but rather that the individual can and does influence it quite substantially. Health is produced by choosing life style, making better and worse health states more or less probable, and by using medical advice, pharmaceuticals, hospital treatment, etc. in order to restore good health (28).

Grossman’s introduction of the demand-for-health model (19, 20) constituted an advance in the economic analysis of individual health behaviour and resulted in that health henceforth could be analyzed in the same way as other types of human capital. Thus, in analogy with investments in market-related human capital, e.g., education, aiming at increasing one’s income and at reducing the risk of unemployment, it is possible to invest in one’s health. However, health capital is intrinsically different from other types of human capital in one particular way: while other types of human capital increase productivity, health capital affects the time available for productive use – the investment aspect of health. In addition, there is also a consumption aspect of health, which means that individuals enjoy good health in its own right.

In the demand-for-health model it is assumed that the stock of health capital depreciates at a rate which increases with time; the depreciation rate may differ among individuals. In order to keep the stock of health capital at the desired level, the individual has to make investments in health capital. Further, because the stock

of health capital depreciates at each point in time, the investments made will also depreciate at that point in time. Therefore, the model distinguishes between produced health investments, or gross health investments, and the realized increase in the stock of health capital, or net health investments, which, hence, equals gross health investment minus depreciation. Furthermore, if the individual experiences (psychic, time or monetary) costs when adjusting from actual to a desired level of health, it pays for the individual to spread his or her gross investments in health and make partial adjustments to the desired stock of health in future time periods. If the individual, however, perceives no costs of adjustment from actual to desired, or demanded, stock of health, actual stock of health capital always equals desired stock of health capital; the adjustment from actual to desired stock of health is instantaneous.

Gross health investments are produced by the individual (or the household) with market-produced goods (medical care, for instance) and own time as inputs to production. Individual health behaviour is influenced by the fact that the individual both demands and produces his or her own health. Exogenous forces may affect the individual’s demand for health, the individual’s production of health, or both. This dichotomy of the individual’s health behaviour in demand and supply factors will be used when predicting the effects of various variables on the demand for health and health investments.

Empirical estimations of the demand for health model have used American (20), Finnish (29), Danish (30), and Swedish data (31). The idea that there might be a cost for adjusting from actual to desired stock of health has been introduced (32) and further extended (33). Bolin *et al.* (33) developed a theoretical and empirical cost-of-adjustment version of the Grossman model, based on the specifications suggested by Jacobson (23) and Grossman (27). In their model (33), both past and future stocks of health are expected to be positively correlated with the current stock of health. The model was estimated using individual panel data from a sample of all 16–84 years old Swedes in 1980/1981, 1988/89, and 1996/97. The study did not focus any particular health condition.

The purpose of this study was to examine whether those who suffer from the chronic conditions of asthma and allergy differ from the general population regarding their health and health-related behaviour, using the theoretical and empirical framework developed by Bolin *et al.* (33) and the same data set. Thus, the model takes into account the fact that most individuals lead a great part of their lives in families, a fact that influences health and health-related behaviour. The paper proceeds as follows. First, the predictions from our theoretical and empirical framework (33) will be reproduced. Secondly and thirdly, the data will be presented and the specific empirical methods used in the paper described. Fourthly, the models will be estimated and the effects of asthma

and allergy, respectively, will be examined separately. Finally, the paper concludes with a discussion of the results. The paper complies with the recommendations of the EAACI nomenclature task force (34).

Predictions

The predictions regarding the effect of exogenous variables on demand for health and health investments following from the theoretical and empirical framework (33) are summarized in Table 1. The predictions regarding asthma and allergy are explained below. The reader is referred to (33) for derivations of the predictions.

The impact of asthma and allergy

The presence of asthma or allergy is predicted to lower the level of health, whereas the effect on investments in health is indeterminate. People who suffer from asthma or allergy will have higher rates of depreciation and, hence, have higher net costs of health capital than those without chronic illnesses. This will lower their demand for health and their realised health levels. Moreover, people who suffer from asthma or allergy may be less efficient producers of gross health investments. Thus, an individual who suffers from asthma or allergy may produce a smaller amount of gross health investment from a given amount of inputs such as time and health care. If productivity is sufficiently low, the demand for gross health investment will increase, even though there is a decrease in the demand for health. If not, the demand for gross health investment will decrease.

Cost of adjustment from actual to desired stock of health

Adjustments to a desired level of health seldom can be done instantaneously without a cost. It therefore pays for the individual to spread his or her gross investments in health and make partial adjustments to the desired stock of health in future time periods. It follows that positive correlations between the current stock of health capital and both the past and the future stock of health capital, respectively, would then be expected (27). It also follows that, while past investments in health should be positively correlated with the future stock of health, they should be negatively correlated with the past stock of health.

Data and statistical methods

Data

A set of individual panel data was created from the Swedish biannual survey of living conditions, ULF (Undersökningar av levnadsförhållanden). In ULF, a sample of approximately 16,000 people, 16–84 years' old, are interviewed about their living conditions; the response rate is normally 80–85%. Every survey covers a

Table 1 Predictions concerning the effects on the demand for health capital and health investment from changes in explanatory variables

Variable	Health capital	Health investment
Age	–	+ –
Wage	+ –	+ –
Asthma	–	+ –
Allergy	–	+ –
Wealth	+	+
Married or cohabiting	+	+
Children	+ –	–
Sex	+ –	+ –

See reference (33).

number of areas: housing, leisure, health, employment, education, private financial situation, and social relations. Responses are supplemented from administrative registers with individual data on income, taxes and various transfer payments. There is also a rolling schedule of extra coverage of some specific areas every 8th year. Thus, there was both a broader and deeper coverage of health-related variables in 1980/81, 1988/89, and 1996/97. Furthermore, approximately 40% of the respondents are part of a rotating panel in which respondents are interviewed every 8th year. Thus, the data set that we used contained health-related and background information for a panel consisting of approximately 3800 individuals for the years 1980/81, 1988/89, and 1996/97.

The choice of year of observation for each variable must be consistent with the empirical model. Thus, we used the indicator for health in 1980/81, 1988/89 and 1996/97, the indicator for health investment in 1980/81, and explanatory variables for 1988/89. Chosen variables from the data set are described below; means and standard deviations are reported in Table 2.

Dependent variables

- SRH1 is a discrete variable, which reflects the self-assessed health in 1988/89. The respondent was asked to report his or her health status as one of three categories: 1, 2 or 3, where 3 is the category with highest health status. (All dependent discrete variables were re-scaled so that the ordinal scale begins at 0). The variable was chosen in order to be an indicator of the unobserved variable health.

- DAYS is a count variable for the number of days of work-absenteeism during the last 3 weeks prior to the interview in 1980/81.

Explanatory variables

- SRH0 is the same as SRH1 but for 1980/81.
- SRH2 is the same as SRH1 but for 1996/97.
- ASTHMA is a dummy variable, which takes the

Table 2 Descriptive statistics. Mean values and standard deviations of dependent and explanatory variables. The values are calculated using individuals who participated in all the ULF surveys of 1980/81, 1988/89, and 1996/97

Variable	Total sample (n=3749)		Asthmatic (n=72)		Allergic (n=83)	
	Mean	SD	Mean	SD	Mean	SD
Dependent variables						
SRH1	2.76	0.49	2.28	0.74	2.76	0.50
DAYS	0.59	2.41	1.90	4.33	0.75	2.48
Explanatory variables						
Srh0	2.80	0.46	2.32	0.77	2.78	0.48
Srh2	2.31	0.58	1.94	0.67	2.22	0.58
Age	46.63	14.60	48.05	15.38	39.21	12.91
Wage	52.27	48.20	45.45	39.89	56.78	33.87
Asthma	0.019	0.137	–	–	0.08	0.27
Allergy	0.022	0.147	0.15	0.36	–	–
Wealth	2262.00	9100.00	3979.0	12989.00	868.00	1977.00
North	0.23	0.42	0.23	0.43	0.25	0.44
Exercise	2.78	1.20	2.61	1.20	2.72	1.19
Smoker	0.27	0.44	0.24	0.43	0.22	0.42
F smoker	0.28	0.45	0.29	0.46	0.31	0.46
Married	0.75	0.43	0.79	0.41	0.70	0.46
Child	0.86	1.09	0.89	1.08	0.94	1.17
Sex	0.47	0.50	0.44	0.50	0.41	0.49

value 1, if the respondent was diagnosed with asthma in 1988/89 and 0 otherwise. (A respondent was defined as being an asthmatic if he or she stated that he or she had been diagnosed with code 493 according to the ICD9 coding).

- **ALLERGY** is a dummy variable, which takes the value 1, if the respondent was diagnosed with allergy in 1988/89 and 0 otherwise. (A respondent was defined as suffering from allergy if he or she stated that he or she had been diagnosed with at least one of the codes 477, 691, or 692 according to the ICD9 coding).

- **AGE** is the respondent’s age in years in the panel 1988/89.

- **WAGE** is a continuous variable for the respondent’s wage rate.

- **WEALTH** is the respondent’s income from capital in 1988/89. Measured in hundreds of SEK.

- **MARRIED** is a dummy variable, which takes the value 1, if the respondent was either married or cohabiting in 1988/1989 and 0 otherwise.

- **CHILD** is the number of children 1988/1989 in the household.

- **EXERCISE** is a discrete variable, which can take the values 1, 2, 3, 4 or 5, where 1 indicates that the respondent does not exercise at all; 5 indicates that the respondent exercises regularly at least twice a week; and 2, 3 and 4 indicate exercise levels in between. The exercise levels are for 1988/89.

- **SMOKER** is a dummy variable, which takes the value 1, if the respondent is a smoker (smokes daily) and 0 otherwise;

- **FSMOKER** is a dummy variable, which takes the value 1, if the respondent has been a smoker and 0 otherwise.

- **SEX** reflects sex: 0 corresponds to the respondent being a female and 1 corresponds to the respondent being a male.

- **NORTH** is a dummy variable, which takes the value 1, if the respondent was living in the north of Sweden in 1988/89 and 0 otherwise.

Statistical method

Self-assessed health was reported as an ordinal ranking, so we estimated an ordered probit model for the demand-for-health equation (35, pp. 926–931). Since, however, the number of days of work-absenteeism is a count variable, we estimated a Poisson model for the investment equation (35, pp. 931–935).

For each independent variable, the marginal effect, i.e., the effect on the dependent variable of a change in an explanatory variable, will be calculated. In a linear regression model, for instance, the ordinary least squares (OLS) model, the marginal effect is identical with the estimated parameter coefficient and, hence, obtained automatically. However, in a nonlinear regression model such as the present one, there is no such relationship. Instead, the marginal effects have to be calculated, given the estimated parameters.

Results

The main results are summarized in Table 3. The results from the two sets of estimated equations were qualitatively identical, i.e., a significant marginal effect (at the 5% level) had the same sign, regardless of whether the condition was asthma or allergy.

Table 3 Estimated effects on the demand for health capital and health investment from changes in independent variables for people suffering from asthma and allergy, respectively, in relation to the general population

Variable	Asthma		Allergy	
	Health capital	Health investment	Health capital	Health investment
Srh0	+	-	+	-
Srh2	+	-	+	-
Asthma/allergy	-	+	n.s.	+
Age	-	-	-	-
Wage	+	n.s.	+	n.s.
Wealth	+	+	+	+
North	-	n.s.	n.s.	n.s.
Exercise	+	+	+	+
Smoker	-	+	n.s.	+
Fsmoker	-	+	-	+
Married	+	n.s.	+	n.s.
Child	n.s.	n.s.	n.s.	n.s.
Sex	+	-	+	-

The impact of asthma and allergy

While asthmatics, as expected, were found to be less healthy than the general population, the health levels reported by those who suffer from allergy did not differ significantly from the general population. However, both asthmatics and those who suffer from allergy invested more in health, days of work-absenteeism, than the general population.

Other variables

There was a significant decrease in the demand for health investment with age. The estimated marginal effect of an increase in the wage rate was positive for the demand for health while not significant for the number of days of work-absenteeism. This implies that the investment aspects of health capital out-weighed the consumption aspects; an increase in the wage rate would

make health capital relatively more valuable and induce the individual to increase his or her stock of health capital.

Both smokers and former smokers were found to demand lower levels of health capital than those who had never smoked. However, smokers and former smokers were also found to invest more in health than the general population. Our result implies that the change in the supply of health capital exceeded the change in the demand for health capital.

Men appeared to be healthier than women. The number of days of work-absenteeism was higher, however, if the respondent was a woman; in other words, women seemed to invest more in their health than men do.

Estimated marginal effects

Estimated marginal effects are presented in detail in Tables 4–7. The marginal effect indicates how the probability of observing a specific value for the dependent variable changes when that independent variable changes. For example: the marginal effect of the variable *asthma* connected to the lowest health state, $srh1 = 0$, is positive (Table 4). Because the variable *ASTHMA* takes the value 1 if the respondent is an asthmatic and 0 otherwise, the calculated marginal effect implies that, if the respondent is an asthmatic, the probability that he or she perceives himself or herself to be in the lowest health status increases.

Discussion and conclusion

In this paper, we examined the effects of asthma and allergy on individual health behaviour. We estimated a dynamic cost-of-adjustment model of the demand for health and health investments. According to our results, asthma affected both health level (negatively) and gross health investment (positively). The relationship between

Table 4 Marginal effects for the ordered probit model of the health capital equation. Self-assessed health as indicator of health capital¹

Variable	Srh1 = 0 (low)		Srh1 = 1 (medium)		Srh1 = 2 (high)	
	Marginal effects	P-values	Marginal effects	P-values	Marginal effects	P-values
Constant	-0.004	0.251	-0.035	0.188	0.040	0.189
Srh0	-0.016*	0.000	-0.148*	0.000	0.164*	0.000
Srh2	-0.015*	0.000	-0.141*	0.000	0.155*	0.000
Age	2.0E-4*	0.000	0.002	0.073	-0.002*	0.000
Wage	-2.676*	0.035	-25.620	0.277	28.296*	0.033
Asthma	0.011*	0.001	0.109	0.141	-0.120*	0.000
Wealth	-0.017*	0.031	-0.167	0.273	0.184*	0.029
North	0.002	0.056	0.020	0.308	-0.022	0.057
Exercise	-0.004*	0.000	-0.035*	0.007	0.038*	0.000
Smoker	0.002	0.095	0.017	0.342	-0.019	0.103
Fsmoker	0.004*	0.002	0.038	0.182	-0.043*	0.002
Married	-0.002*	0.048	-0.021	0.299	0.023*	0.049
Child	-5.0E-4	0.197	-0.005	0.382	0.006	0.172
Sex	-0.003*	0.016	-0.025	0.246	0.027*	0.016

¹Bold indicates that the estimated coefficient is significant at the 10% level, and bold and * indicate that the coefficient is significant at the 5% level. Notice that in order for LIMDEP to work we had to rescale the dependent variables. 1 has been assigned the value 0, 2 has been assigned the value 1 and so on.

Table 5 Marginal effects for the Poisson model of the health investment equation. Work-absenteeism as indicator of health investments¹. Asthma included as an explanatory variable!

Variable	Change in the expected number of days of work-absenteeism	
	Marginal effect	P-value
Constant	0.574*	0.000
Srh0	– 0.530*	0.000
Srh2	– 0.122*	0.000
Age	– 0.005*	0.000
Wage	18.870	0.611
Asthma	0.391*	0.000
Wealth	0.396*	0.000
North	0.006	0.889
Exercise	0.086*	0.000
Smoker	0.360*	0.000
Fsmoker	0.259*	0.000
Married	0.010	0.804
Child	–0.004	0.818
Sex	– 0.113*	0.001

¹Bold indicates that the estimated coefficient is significant at the 10% level, and bold and * indicate that the coefficient is significant at the 5% level.

allergy and the health level was not statistically significant, but there was a statistically significant positive correlation between allergy and health investment. Certainly, there are a few studies reporting lower health-related quality for patients with asthma and/or allergy but apparently with no direct comparison with the general population (36–43). Our result may indicate that asthma after all is perceived as a more severe disease including a not negligible mortality risk.

This study focused on the importance of chronic illnesses, here, asthma and allergy, on health-related behaviour. However, concerning other variables than asthma and allergy, our results here were similar to the results for the general population obtained in our previous study (33). That health-related quality of life is not only influenced by the severity of disease but also by demographic and socioeconomic factors has also been reported elsewhere (44).

Besides the results concerning the relationships between asthma and allergy on one hand and individual health behaviour on the other, there are at least two additional results that are particularly important. Firstly, instantaneous adjustment of actual to desired health level was rejected, a finding which confirms the result in (33). Secondly, we found that the family structure has some importance for individual health behaviour because those married or cohabiting were found to be healthier than singles. This corroborates our own previous result (33) and is consistent with the findings of a positive correlation between being married and lower death rates (45–47). Obviously, this result may also be explained by selection effects, i.e., that those marrying are healthier than the average.

As health capital and health investment are unobservables, any empirical implementation of Grossman’s demand-for-health model is faced with the problem of choosing indicators for the unobserved variables; different indicators for health capital and health investment have been used in previous research (19, 29–32). At first, the choice may seem decisive, because an incorrect representation would certainly make the estimates biased. Here, the problem appears to be small. It has been shown recently that the empirical results of the demand-for-health model are qualitatively robust as to the choice of empirical representations of health capital and health investments (33); different choices of relevant indicators of health capital and health investment produced almost identical qualitative results. Thus, the choice of empirical representations for health capital and health investment constitutes less of a problem than might be expected.

In our model, individuals produce gross health investment by using, for instance, work-absenteeism (own time) and health care as inputs. Lower costs of inputs in the individual health production function

Table 6 Marginal effects for the ordered probit model of the health capital equation. Self-assessed health as indicator of health capital¹. Allergy included as an explanatory variable!

Variable	Srh1=0(low)		Srh1 = 1 (medium)		Srh1 = 2 (high)	
	Marginal effects	P-values	Marginal effects	P-values	Marginal effects	P-values
Constant	–0.002	0.345	–0.019	0.319	0.021	0.319
Srh0	– 0.016*	0.000	– 0.152*	0.000	0.168*	0.000
Srh2	– 0.015*	0.000	– 0.142*	0.000	0.158*	0.000
Age	2.0E-4*	0.000	0.002	0.083	– 0.002*	0.000
Wage	– 2.696*	0.036	–25.306	0.280	28.002*	0.034
Allergy	1.0E-4	0.489	0.001	0.496	–0.001	0.487
Wealth	– 0.016*	0.048	–0.148	0.297	0.164*	0.047
North	0.002	0.059	0.020	0.308	– 0.022	0.058
Exercise	– 0.004*	0.000	– 0.034*	0.008	0.038*	0.000
Smoker	0.002	0.112	0.016	0.353	–0.017	0.120
Fsmoker	0.004*	0.002	0.038	0.182	– 0.043*	0.002
Married	– 0.002	0.059	–0.020	0.306	0.022	0.056
Child	–5.0E-4	0.203	–0.005	0.386	0.006	0.179
Sex	– 0.003*	0.017	–0.024	0.247	0.027*	0.016

¹Bold indicates that the estimated coefficient is significant at the 10% level, and bold and * indicate that the coefficient is significant at the 5% level. Notice that in order for LIMDEP to work we had to rescale the dependent variables. 1 had been assigned the value 0, 2 has been assigned the value 1 and so on.

Table 7 Marginal effects for the Poisson model of the health investment equation. Work-absenteeism as indicator of health investment¹. Allergy included as an explanatory variable¹

Variable	Change in the expected number of days of work-absenteeism	
	Marginal effect	P-value
Constant	0.630*	0.000
Srh0	– 0.553*	0.000
Srh2	– 0.126*	0.000
Age	– 0.005*	0.000
Wage	19.260	0.599
Allergy	0.239*	0.008
Wealth	0.419*	0.000
North	0.003	0.942
Exercise	0.083*	0.000
Smoker	0.349*	0.000
Fsmoker	0.250*	0.000
Married	0.002	0.958
Child	–0.006	0.740
Sex	– 0.104*	0.002

¹Bold indicates that the estimated coefficient is significant at the 10% level, and bold and * indicate that the coefficient is significant at the 5% level.

References

- AL FRAYH AR, SHAKOOR Z, GAD EL RAB MO, HASNAIN SM. Increased prevalence of asthma in Saudi Arabia. *Ann Allergy Asthma Immunol* 2001;**86**:292–296.
- BJÖRKSTEN B, DUMITRASCU D, FOUCARD T et al. Prevalence of childhood asthma, rhinitis and eczema in Scandinavia and Eastern Europe. *Eur Respir J* 1998;**12**:432–437.
- FAGAN JK, SCHEFF PA, HRYHORCZUK D, RAMAKRISHNAN V, ROSS M, PERSKY V. Prevalence of asthma and other allergic diseases in an adolescent population: association with gender and race. *Ann Allergy Asthma Immunol* 2001;**86**:145–146.
- HESELMAR B, ÅBERG B, ERIKSSON B, ÅBERG N. Asthma in children: prevalence, treatment and sensitization. *Pediatr Allergy Immunol* 2000;**11**:74–79.
- MORTZ CG, LAURITSEN JM, BINDSLEV-JENSEN C, ANDERSEN KE. Prevalence of atopic dermatitis, asthma, allergic rhinitis, and hand and contact dermatitis in adolescents. The Odense Adolescence Cohort Study on Atopic Diseases and Dermatitis. *Br J Dermatol* 2001;**144**:523–532.
- SELNES A, ODLAND JO, BOLLE R, HOLT J, DOTTERUD LK, LUND E. Asthma and allergy in Russian and Norwegian schoolchildren: results from two questionnaire-based studies in the Kola Peninsula, Russia, and northern Norway. *Allergy* 2001;**56**:344–348.
- SHAHAR E, LORBER M. Prevalence of self-reported allergic conditions in an adult population in Israel. *Isr Med Assoc J* 2001;**3**:190–193.
- LINDGREN B, JACOBSON L. Får hälsoekonomiska studier se ut hur som helst? De samhällsekonomiska kostnaderna för astma och allergi i Sverige. *Läkartidningen* 1995;**92**:1067–1068.
- JACOBSON L, LINDGREN B. Vad kostar sjukdomarna? Sjukvårdskostnader och produktionsbortfall fördelat på sjukdomsgrupper 1980 och 1991. Stockholm: Socialstyrelsen, 1996.
- JACOBSON L, HERTZMAN P, LÖFDAHL CG, SKOOGH BE, LINDGREN B. The economic impact of asthma and chronic obstructive pulmonary disease (COPD) in Sweden in 1980 and 1991. *Respir Med* 2000;**94**:247–255.
- BLAISS MS. Cognitive, social, and economic costs of allergic rhinitis. *Allergy Asthma Proc* 2000;**21**:7–13.
- CRYSTAL-PETERS J, CROWN WH, GOETZEL RZ, SCHUTT DC. The cost of productivity losses associated with allergic rhinitis. *Am J Manag Care* 2000;**6**:373–378.
- LOZANO P, SULLIVAN SD, SMITH DH, WEISS KB. The economic burden of asthma in US children: estimates from the National Medical Expenditure Survey. *J Allergy Clin Immunol* 1999;**104**:957–963.
- SMITH DH, MALONE DC, LAWSON KA, OKAMOTO LJ, BATTISTA C, SAUNDERS WB. A national estimate of the economic costs of asthma. *Am J Respir Crit Care Med* 1997;**156**:787–793.
- WEISS KB, SULLIVAN SD. Socio-economic burden of asthma, allergy, and other atopic illnesses. *Pediatr Allergy Immunol* 1994;**5**:7–12.
- WEISS KB, SULLIVAN SD. The health economics of asthma and rhinitis. I. Assessing the economic impact. *J Allergy Clin Immunol* 2001;**107**:3–8.
- WEISS KB, SULLIVAN SD, LYTTLE CS. Trends in the cost of illness for asthma in the United States, 1985–94. *J Allergy Clin Immunol* 2000;**106**:493–499.
- LINDGREN B. The economics of obstructive lung-disease. *European Respiratory Rev* 2000;**10**:377–379.
- GROSSMAN M. *The Demand for Health: A Theoretical and Empirical Investigation*. Columbia University Press for the National Bureau of Economic Research, 1972.
- GROSSMAN M. On the concept of health capital and the demand for health. *J Polit Economy* 1972;**80**:223–255.
- MUURINEN JM. Demand for health. A generalised Grossman model. *J Health Economics* 1982;**1**:5–28.
- LILJAS B. The demand for health with uncertainty and insurance. *J Health Economics* 1998;**17**:153–170.
- JACOBSON L. The family as producer of health – An extension of the Grossman model. *J Health Economics* 2000;**19**:611–637.

would increase the supply of health investments and the level of individual health. Thus, our empirical results may have implications also for public health policy. Health policy measures, which reduce the individual's costs of investing in his or her health, would improve health levels. Asthmatics were found less healthy than those suffering from allergy, hence the potential gains would be larger for patients with asthma than for patients with allergy. The issue of whether this would be a cost-effective policy or not would require a different design and, could therefore not be solved within the present study.

Acknowledgments

The financial support from the Swedish National Institute of Public Health is gratefully acknowledged. The development and use of the database were facilitated by research grants to Björn Lindgren from the Swedish Social Research Council, the Vårdal foundation, the Swedish National Institute of Public Health, and the Faculty of Medicine at Lund University.

24. BOLIN K, JACOBSON L, LINDGREN B. The family as the producer of health – when spouses act strategically., *Studies in Health Economics* 30. Lund University Centre for Health Economics, 2000.
25. BOLIN K, JACOBSON L, LINDGREN B. The family as the health producer – when employers have incentives of investing in the health of their employees., *Studies in Health Economics* 34. Lund University Centre for Health Economics, 2000.
26. BOLIN K, JACOBSON L, LINDGREN B. The family as the producer of health – when spouses are Nash bargainers. *J Health Economics* 2001;**20**:349–362.
27. GROSSMAN M. The human capital model of the demand for health. In: CULYER, AJ, NEWHOUSE, JP, , eds. *Handbook of Health Economics*. Amsterdam: Elsevier, 2000;347–408.
28. LINDGREN B. The importance of self-management. *Eur Respir Rev* 1996;**6**:108–112.
29. MUURINEN JM. An economic model of health behaviour – with empirical applications to Finnish health survey data. Department of Economics and Related Studies, University of York, 1982 , (Ph D Thesis).
30. WAGSTAFF A. The demand for health: some new empirical evidence. *J Health Economics* 1986;**5**:195–233.
31. SUNDBERG G., The demand for health and medical care in Sweden. In: SUNDBERG G, *Essays on Health Economics*. Economic Studies 26. Department of Economics, Uppsala University 1996, (Ph D Thesis).
32. WAGSTAFF A. The demand for health: an empirical reformulation of the Grossman model. *Health Economics* 1993;**2**:189–198.
33. BOLIN K, JACOBSON L, LINDGREN B. How stable are the empirical results of the Grossman model? -testing different indicators of health capital and health investments in Sweden 1980/81, 1988/89 and 1996/97., *Studies in Health Economics* 36. Lund University Centre for Health Economics, 2001.
34. JOHANSSON SGO, O'B HOURIHANE J, BOUSQUET J et al. A revised nomenclature for allergy. An EAACI position statement from the EAACI nomenclature task force. *Allergy* 2001;**56**:813–824.
35. GREENE WH. *Econometric Analysis*, 3rd edn. New York: Prentice Hall, 1997.
36. BLUMENSCHNEIN K, JOHANNESSON M. Relationship between quality of life instruments, health state utilities, and willingness to pay in patients with asthma. *Ann Allergy Asthma Immunol* 1998;**80**:189–194.
37. DEREBERY MJ, BERLINER KI. Allergy and health-related quality of life. *Otolaryngol Head Neck Surg* 2000;**123**:393–399.
38. EHRS PO, ÅBERG H, LARSSON K. Quality of life in primary care asthma. *Respir Med* 2001;**95**:22–30.
39. GARRATT AM, HUTCHINSON A, RUSSELL I. Patient-assessed measures of health outcome in asthma: a comparison of four approaches. *Respir Med* 2000;**94**:597–606.
40. HUSS K, NAUMANN PL, MASON PJ, et al. Asthma severity, atopic status, allergen exposure and quality of life in elderly persons. *Ann Allergy Asthma Immunol* 2001;**86**:524–530.
41. LEYNAERT B, NEUKIRCH C, LIARD R, BOUSQUET J, NEUKIRCH F. Quality of life in allergic rhinitis and asthma. A population-based study of young adults. *Am J Respir Crit Care Med* 2000;**162**:1391–1396.
42. LUNDBERG L, JOHANNESSON M, SILVERDAHL M, HERMANSSON C, LINDBERG M. Quality of life, health-state utilities and willingness to pay in patients with psoriasis and atopic eczema. *Br J Dermatol* 1999;**141**:1067–1075.
43. SCHMIER JK, CHAN KS, LEIDY NK. The impact of asthma on health-related quality of life. *J Asthma* 1998;**35**:585–597.
44. APTER AJ, REISINE ST, AFFLECK G, BARROWS E, ZUWALLAC RL. The influence of demographic and socioeconomic factors on health-related quality of life in asthma. *J Allergy Clin Immunol* 1999;**103**:72–78.
45. FUCHS V. *Who Shall Live? Health, Economics and Social Choice*. New York: Basic Books, 1974.
46. TAUBMAN P, ROSEN S. Healthiness, education, and marital status. In: FUCHS, V, , ed. *Economic Aspects of Health*. Chicago: University of Chicago Press, 1982.
47. SMITH K, WAITZMAN N. Double jeopardy. Interaction effects of marital and poverty status on the risk of mortality. *Demography* 1994;**31**:487–493.